Arkansas
Department of Human Services

ARKANSAS DEPARTMENT OF Health
Keeping Your Hometown Healthy

Arkansas Early Childhood Comprehensive Systems Initiative

JOINT MEETING: Medical Home and Social-Emotional Health Work Groups

July 21, 2005, 2 – 4 p.m.

Members Present: Patty Bokony, Gil Buchanan, Laura Butler, Stevie Cherepski, Bruce Cohen, Deborah Gangluff, Mary Gupton, Shyreeta Hicks, Richard Hill, Tabitha Lee, Lynn Lincoln, Sherry Jo McLemore, Ann Patterson, Delores Pinkerton, Martha Reeder, Paula C. Watson and Anne Wells

Regrets: John Allen, Rachel Bowman, Dana Gonzalez, Betti Hamilton, Carol Lee, Belinda Sanders, and Suzette Schutze, Dan Sullivan.

Agenda Item #1: AECCS and SFI Update – Martha Reeder

Discussion: ***AECCS***. There are 17 components that the MCHB demands to be addressed in the final state plan. In one way or the other, these 17 components need to be addressed when the final plan is written. Martha shared this section of the recent grant application. The bold print indicates how the 17 components are currently being addressed. Our goal with the AECCS is to complete the State Plan by March 2006. The plan will show some things in progress, some in place, and others in planning stages.

Many states have already filed their plans. The information is available to review on the web. The website is as follows:
www.hsrnet.net/eccs/state_plans.htm

Strengthening Families Initiative (SFI Si centers were chosen for the Promising Practice Program PPP . The Promising Practices Programs will serve as peer mentors to other early care programs in their region of the state. The si selected Promising Practice Programs include a variety of centers:

- A 21st Century School
- Headstart
- amily ay Care Home
- Special Health Care eeds

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Si teen programs made application to become Promising Practice. The remaining ten programs are invited to oin a learning networ of programs that will be led by the Promising Practice Programs and the S I leadership team.

All uality Approved programs are eligible to participate in the S I etwor . If you now of uality programs that meet the baseline ualifications, they can be part of the etwor . They must have a team composed of the director, staff member, and parent who is part of the parent organi ation. They must be willing to do the self-assessment, participate in conference calls and the development of the tool it, and committed to be involved in any program training opportunities. Interested programs should contact the office immediately.

All programs in the S I etwor will be invited to participate in a series of technical assistance conference calls, the first of which is scheduled for August . In addition, a full day of activities will be offered to all networ members on the pre-conference day of the Ar ansas Early Childhood Association Conference October 1 in Hot Springs.

Agenda Item #2: Concept for Small Conference Grant Proposal – Deborah Gangluff

Discussion: ***VCHIP.*** The CHIP proposal was not funded. The states that were funded were ew or , hode Island, Ari ona, ashington State, and also ashington, .C. e were in the final twelve. A positive outcome from the development of the proposal was the engagement of three statewide clinics that currently serve children: Ar ansas Children s Hospital, Baptist Health, and Community Health Centers. Even though the pro ect was not funded, we should stay engaged with these programs. It might be possible to lin any of these willing partners with child care pro ects, such as the Promising Practice Programs of Strengthening ami-lies.

One of the activities that the CHIP grant was the convening of the meeting of the child care and health care concerns. ana, eborah, and Martha met together to brainstorm about what could be done to secure other funding.

There are some conference grant proposals that are ongoing. eborah and ana are obtaining information to apply for a conference grant. One grant proposal funds up to 0,000 and another one will fund up to 1 0,000. Most of the conference grants are based on research including distributing research information.

Martha referred to a research that lin s the child care and health care systems. One of the ideas for the conference grant is to have a train the trainer wor shop and have an application for those interested in attending to be a part of the pro ect. The conference money will be used to reimburse the participants for attending the conference. The participants in return will promise to complete other trainings in the state for a certain number of times over the ne t year.

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esearch indicates five strategies that utili e the child care setting to--

- Provide Surveillance and Assessment
- Provide Preventive Health Care in Child Care Centers
- Provide Parent Education Opportunities
- Increase training of child care professionals that support children s health and well-being
- esearch and enroll uninsured children through such programs as *Covering Kids and Families.*

The following is a lin to the research from the obert ood ohnson oundation: www.rw f.org/files/research/lin ChildCare 20 2 .pdf

Open Space Technology. Sherri o Mc emore shared another concept that we might want to pursue: Open Space Technology. One e planation of this format, according to the website www.openspaceworld.com is:

In pen Space meetings, events and organiza tions, participants create and manage their own agenda of parallel working sessions around a cen tral theme of strategic importance, such as: What is the strategy, group, organization or community that all stakeholders can support and work together to create a better system With groups of 5 to working in one day workshops, three day conferences, or the regular weekly staff meeting – the common result is pow erful, effective, connecting and strengthening of what s already happening in the organization: planning and action, learning and doing, passion and responsibility, participation and performance.

Agenda Item #2, Continued: Concept Small Conference Grant Proposal – Deborah Gangluff	
Discussion: The conference needs to be framed around a research topic in order to satisfy the re- uirements of funders. It must be relevant to both child care and health care professionals. The ob- ect is to initiate a meaningful discussion, and to target and engage the entities who have a vital in- terest in improving health care for children as a part of their mission. Bruce secured materials from Illinois regarding a recent conference related to medical care and child care concerns. The overall topic in the Illinois Con- ference was, Building a Medical Home. They were targeting children with special health care needs and identifying those groups wor ing with children. The train the trainer wor shop was specifically for physicians, but organi ers complained that very few physicians attended. It was suggested that we might plan to partner with the AMS program, Partners in Behavior Health Sciences, and as them to co-sponsor such an event in Ar ansas. Another suggestion was to engage three or four co-sponsors. The option of using TeleMedicine televideo technology to con- nect spea ers to remote sites with on site facilita- tors was proposed. Other comments and discussion followed. Sug- gested issues include, How important is early inter- vention and Screening, as well as other topics regarding family concerns with the health of their children. **ne t column**	It was agreed that specific recommendations be sent to eborah angluff and ana on ales as they wor on obtaining conference grant funding. The target audience needs to be identified, and ways to engage this audience need to be deter- mined. Perhaps a survey can be administered to this target audience and used in the construction of the agenda for the conference. r. ugent suggested the idea of plugging into and utili ing an already-e isting format. Also sug- gested was the idea of using focus groups with people who are out there in practice. A possible application of this idea would be to conduct re- gional focus groups, inviting both child care and health care providers. The series of focus groups could culminate in a conference, with results from the focus groups helping to set the agenda for the conference. Perhaps instead of a large gathering, we could stage a focus group and invite five child care pro- viders with the regional groups. . Is this more do- able financially e could still have a confer- ence it would be a culmination of the series of focus groups. At the first meeting of this group in une, Tabitha ee was as ed to investigate how many children are evaluated and referred for services, but do not receive services due to the shortage of pro- fessionals. Tabitha reported that A MC only has claims for things that have been filed. They only have access to children who have received ser- vices. There is no way to trac this information from her office.
Agenda Item # : Screening Materials	
The screening materials were reviewed that were sent by Eldon Schul . See Attachment It was noted that they were not too different from what was previously discussed. Other discussion and comments followed **. ne t column**	Perhaps, we should not recommend ust one meas- ure but suggest a few and let the users chose which one they prefer. If we do the small groups focus perhaps we could as about screening tools. This could be another focal point of the meeting.

Agenda Item # , Continued: Screening Materials	
Discussion: uestion: hat is the difference between screening and surveillance There are medical screens and mental health screens. Somewhere down the line, it needs to be decided what we want to screen. And, then down the row at a different level, you screen something else. If you are going to set up a uality level program, you are going to provide the information giving choices. Some states will pay more if certain tests are done. ou have to pic where you want to be on the spectrum. A suggestion: we only provide funding for your program if you select from these ✍ e determine what is appropriate for the physician to screen **ne t column**	✍ e determine what is appropriate for the center to screen ✍ e determine what is appropriate for the parents to screen. If we are going to get to the heart, perhaps we should have a small group ma e recommendations to the larger group. e need it spelled out to determine whether it is going to be e actly what we want. e need something in which to start. The PE S is the easiest to do. The recommendation would also have to include who administers, age range, how long, etc. How are we going to loo through this Can we pull together in terms of a specific recommendation to the whole group
Agenda Item #4 – Ad ournment – e t Meeting Date	
Discussion: There being no further business, the meeting was ad ourned.	**E T MEETI G DATE:** **September 1 , 2005** **2: 0 – 4: 0 p.m.** **Freeway Medical Center – Room 05**

From: Schulz, Eldon [SchulzEldon@uams.edu]
Sent: Monday, July 11, 2005 12:00 PM
To: Paula C .Watson
Subject: FW: Social-Emotional Screeners

Attachments: PediatricScreeners0505.doc

Greetings, here's the email I sent Dr. B, along with the several page attachment.
Can't believe I found it so fast, left it right were I put it!!!
Eldon

-----Original Message-----
From: Eldon Schulz [mailto:egs1@swbell.net]
Sent: Tuesday, May 31, 2005 6:13 PM
To: Gil Buchanan
Cc: Schulz, Eldon
Subject: Social-Emotional Screeners

Gil, attached is the materials I researched for the meeting, which I thought was today.
As I recall, the ASQ (Ages and Stages
Questionnaire) has a Social-Emotional tool that can adjunct the basic tool.

The three points I had planned to make:
-hands-on screening tools, like the Denver, have been replaced with parent and/or teacher completed questionnaires, which have good sensitivity and specificity and are far easier to administer and score

-screening instruments are not diagnostic tools, most are a "pass or fail" scoring system.

-because they identify false-positive and false-negative cases, a trained professional needs to follow up. Therefore, centers must establish "relationships" with providers (pediatrician, mental health provider, etc) in their community to review the identified cases, administer additional diagnostics and help in establish a management plan

-it will take a bit more investigating to recommend a single tool, as I don't know all the pros and cons of each tool that I've included in the attachment; it's a starting point for the discussion. One question, what are they trying identify?

Eldon

http://www.fpnotebook.com/PED52.htm has an excellent overview of multiple instruments

Pediatric Symptom Checklist

http://psc.partners.org/psc_general.htm

The following information relates to the psychometric properties of the PSC:

Instructions for Scoring: The PSC consists of 35-items that are rated as never, sometimes, or often present and scored 0, 1, and 2, respectively. Item scores are summed and the total score is recoded into a dichotomous variable indicating psychosocial impairment. For children aged six through sixteen, the cut-off score is 28 or higher. For four and five year-old children, the PSC cut-off is 24 or higher (Little et al, 1994; Pagano et al, 1996). Items that are left blank by parents are simply ignored (score = 0). If four or more items are left blank, the questionnaire is considered invalid.

How to Interpret the PSC: A positive score on the PSC suggests the need for further evaluation by a qualified health (M.D., R.N.) or mental health (Ph.D, LICSW) professional. Both false positives and false negatives occur, and only an experienced clinician should interpret a positive PSC score as anything other than a suggestion that further evaluation may be helpful. Data from past studies using the PSC indicate that 2 out of 3 children who screen positive on the PSC will be correctly identified as having moderate to serious impairment in psychosocial functioning. The one child "incorrectly" identified usually has at least mild impairment, although a small percentage of children turn out to have very little actually wrong with them (e.g., an adequately functioning child of an overly anxious parent). Data on PSC-negative screens indicate 95% accuracy, which, although statistically adequate, still means that 1 out of 20 children rated as functioning adequately may actually be impaired. The inevitability of both false-positive and false-negative screens underscores the importance of experienced clinical judgment in interpreting PSC scores. Therefore, it is especially important for parents or other lay people who administer the form to consult with a licensed professional if their child receives a PSC-positive score.

Validity: Using a Receiver Operating Characteristic Curve, Jellinek, Murphy, Robinson, et al (1988) found that a PSC cutoff score of 28 has a specificity of 0.68 and a sensitivity of 0.95 when compared to clinicians' ratings of children's psychosocial dysfunction. In other words, 68% of the children identified as PSC-positive will also be identified as impaired by an experienced clinician, and, conversely, 95% of the children identified as PSC-negative will be identified as unimpaired.

Reliability: Test-re-test reliability of the PSC ranges from $r = .84 - .91$. Over time, case/not case classification ranges from 83% - 87%. (Jellinek & Murphy, 1988; Murphy et al, 1992).

Inter-item Analysis: Our studies (Murphy & Jellinek, 1985; Murphy, Ichinose, Hicks, et al, 1996) also indicate strong (Cronbach alpha = .91) internal consistency of the PSC items and highly significant ($p < 0.0001$) correlations between individual PSC items and positive PSC screening scores.

Qualifications for Use of the PSC: The training required may differ according to the ways in which the data are to be used. Professional school (e.g., medicine or nursing) or graduate training in psychology of at least the Master's degree level would ordinarily be expected. However, no amount of prior training can substitute for professional maturity, a thorough knowledge of clinical research methodology, and supervised training in working with parents and children. There are no special qualifications for scoring.

Parents' Evaluation of Developmental Status (PEDS)

www.pedstest.com

Parents' Evaluation of Developmental Status (PEDS) is a fast and inexpensive method for detecting developmental and behavioral problems in children from birth to age eight. PEDS helps providers make evidence-based decisions about children's and families' needs by eliciting and weighing parents' concerns. Meeting standards set by the American Academy of Pediatrics for screening tests, PEDS is not only a screen but also a longitudinal surveillance tool that can be used for early detection, monitoring, intake and triage. PEDS is also useful in population surveillance and other research initiatives. The subject of multiple peer-reviewed studies, PEDS has demonstrated standardization, reliability, validity, and accuracy.

Achenbach Parent and Child Behavior Checklist

www.fasttrackproject.org/techrept/t/trf/

The *Teacher's Report Form* (Achenbach System of Empirically Based Assessment 1991), evaluates behavior problems that a child may display in school. The full version includes Adaptive Functioning and Academic Performance sections, but these were not included in this version of the measure. Only the Problem Section was used in the Fast Track Project. The *Child Behavior Checklist* (Achenbach 1991) is a parent measure that also evaluates behavior problems a child may display and was collected at the same time as the TRF and measures the same constructs. Both are considered to be extremely reliable measures of behavior problems.

Each item on the Problem Section of the TRF contains a statement about a child's behavior. The teacher selects the response that assesses how well each statement describes the child, either currently or within the previous two months. Response choices include: "Not True" (0), "Somewhat or Sometimes True" (1), and "Very True or Often True" (2).

Analysts should note that a number of scores were positively distributed for both the normative and the high-risk samples. For year 1, analysis of scores on four raw scores, three T scores, and five Fast Track narrow band scales showed a floor effect. In addition, it needs to be noted that a number of items in the scores had a zero variation. Scores affected by the zero variation for some items included the Delinquency Raw Score (high-risk boys), the Somatic Complaints Raw Score (high-risk and normative girls), the Thought Problems Raw Score (normative boys and girls), and the Total Problems Raw Score (high-risk boys and girls and normative boys and girls).

Caution should be used in analyzing the raw score versions of the Achenbach scales with males and females, as the scores are based on different items. This does not apply to the T-scores (which are normed separately by gender) or the Fast Track narrow band scales (which use the same items for each gender).

Finally, analysts should note that two scores, the Somatic Complaints Raw Score and the Somatic Complaints T Score, both showed differences between the control and intervention groups in the combined sample and in the boys only sample.

Keywords: Delinquency, Aggression, Attention Problems, Withdrawal, Anxiety, Depression, Somatic Complaints, Social Problems, Behavior Problems, Antisocial Behavior, Emotional Disturbances, Self Injury.

15 September 2004

PedsQL

http://www.pedsql.org/

The PedsQL Measurement Model is a modular approach to measuring health-related quality of life (HRQOL) in healthy children and adolescents and those with acute and chronic health conditions. The PedsQL Measurement Model integrates seamlessly both generic core scales and disease-specific modules into one measurement system.

The PedsQL Generic Core Scales are:

Brief (23 items)
Practical (Less than 4 minutes to complete)
Flexible (Designed for use with community, school, and clinical pediatric populations).
Developmentally Appropriate (Ages 2-18; Child Self-Report Ages 5-7, 8-12, 13-18; Parent Proxy-Report Ages 2-4, 5-7, 8-1
Multidimensional (Physical, Emotional, Social, School Functioning).
Reliable (Total Scale Score: 0.88 Child Self-Report; 0.90 Parent Proxy-Report).
Valid (Distinguishes between healthy children and children with acute and chronic health conditions; distinguishes disease se
tion).
Responsive to clinical change over time.
Translated into multiple languages including broadcast Spanish.

The **23-item PedsQL Generic Core Scales** were designed to measure the core dimensions of health as delineated by the World Health Organization, as well as role (school) functioning. The 4 **Multidimensional** Scales and 3 Summary Scores are:

Scales	Summary Scores
Physical Functioning (8 items)	**Total Scale Score** (23 items)
Emotional Functioning (5 items)	**Physical Health Summary Score** (8 items)
Social Functioning (5 items)	**Psychosocial Health Summary Score** (15 items)
School Functioning (5 items)	

The PedsQL Condition-Specific Modules
Complement the Generic Core Scales for use in designated clinical populations.
Designed to provide greater measurement sensitivity for circumscribed populations.
Disease-Specific Modules available for asthma, rheumatology, diabetes, cancer, and cardiac conditions, with additional modules in the development and planning stages.

Newsletter for the PedsQL Pediatric Quality of Life Inventory
Sample PedsQL Child-Self Report (ages 8-12)
Sample PedsQL Parent-Proxy Report for Children (ages 8-12)

Ages and Stages Questionnaires

www.brookespublishing.com/store/books/bricker-asq

Ages & Stages Questionnaires® (ASQ)
A Parent-Completed, Child-Monitoring System, *Second Edition*
By Diane Bricker, Ph.D., & Jane Squires, Ph.D., with assistance from Linda Mounts, M.A., LaWanda Potter, M.S., Robert Nickel, M.D., Elizabeth Twombly, M.S., and Jane Farrell, M.S.

The **Ages & Stages Questionnaires® (ASQ)** system is a low-cost, reliable way to screen infants and young children for developmental delays during the crucial first 5 years of life.

Parents complete the simple, illustrated 30-item questionnaires at designated intervals, assessing children in their natural environments to ensure valid results. Each questionnaire can be completed in just 10-15 minutes and covers five key developmental areas: communication, gross motor, fine motor, problem solving, and personal-social.

Professionals convert parents' responses of **yes, sometimes,** and **not yet** — in just 2-3 minutes — to color-coded scoring sheets, enabling them to quickly determine a child's progress in each developmental area. **The ASQ User's Guide** then offers clear guidelines for determining whether children are at high or low risk in the various domains.

ASQ keeps costs down by providing **photocopiable forms** (see **photocopying release**) that can be mailed to parents. Or, the questionnaires can be completed by parents during home visits — there's a helpful video that demonstrates the process. And questionnaires are also **available in Spanish, French, and Korean** for professionals who work with families that speak those languages. It's a flexible, culturally sensitive, and economical way to track the developmental progress of young children.

Eight new questionnaires, added to this edition as a result of user feedback, extend the age-range of the system and help to create a more authentic means of measuring the rapidly developing skills of young children.

Questions about parent involvement, accuracy of results, or ease of administration? Visit this **Fast Facts** sheet for answers.

The complete **ASQ** system includes:

- 19 color-coded, photocopiable questionnaires for use at 4, 6, 8, 10, 12, 14, 16, 18, 20, 22, 24, 27, 30, 33, 36, 42, 48, 54, and 60 months of age
- 19 photocopiable, age-appropriate scoring sheets — one for each questionnaire
- 1 convenient storage box

The ASQ User's Guide, which has been revised and expanded to help professionals accurately administer the questionnaires and confidently interpret their results. Includes sample parent-child activities for each age range.